## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS  SITEET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410  (X4.1)D (RESULATORY OR LSC IDENTIFYING INFORMATION)  K 000  INITIAL COMMENTS  A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.  Survey Date: 08/22/12  Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890  Surveyor: W. Chris Greeney, Life Safety Code Specialist, At this Quality Assurance Walk-thru survey, Spring Mill Health Campus was found in compliance with 410 IAC 16.2-3.1-19(ff).  This fully sprinklered facility was located on one wing on the first and second floors of a two story building, and the first floor of a 2007 wing addition determined to be of Type V (111) construction. The facility has a fire alarm system with hard-wired smoke detection in all resident rooms, corridors and spaces open to the corridors. The facility has sfound in compliance with state	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (PAGE) GENCIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  K 000  INITIAL COMMENTS  A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.  Survey Date: 08/22/12  Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890  Surveyor: W. Chris Greeney, Life Safety Code Specialist, At this Quality Assurance Walk-thru survey, Spring Mill Health Campus was found in compliance with 410 IAC 16.2-3.1-19(ff).  This fully sprinklered facility was located on one wing on the first and second floors of a two story building, and the first floor of a 2007 wing addition determined to be of Type V (111) construction. The facility has a fire alarm system with hard-wired smoke detection in all resident rooms, corridors and spaces open to the corridors. The facility was found in compliance with state	AND PLAN OF CORRECTION		IDENTIFICATION NOWIBER.			G <b>02</b>	COMITLETED	
SPRING MILL HEALTH CAMPUS    CALLID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DEFICIENCY	155764		155764	B. WING			08/22/2012	
Summary Statement of Deficiencies   ID   PREFIX   (EACH DEFICIENCY Must be Preceibed by Pull   PREFIX   (EACH DEFICIENCY Must be Preceibed by Pull   PREFIX   (EACH DEFICIENCY Aust be Preceibed by Pull   PREFIX   (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)      K 000   INITIAL COMMENTS   K 000						101 W 87TH AVE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE COME TO BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE COME TO BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE COME TO BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE COME TO BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (NOTION THE APPROPRIATE DEFICIENCY)  (K 000  (K						<u> </u>		
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law in regard to sprinkler coverage and in regard to smoke detector coverage.		law in regard to sprink	kler coverage and in regard					
All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.		access were sprinkler	red and all areas providing					
Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/28/12.  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DAT		Code Specialist-Medi	cal Surveyor on 08/28/12.					(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02		(X3) DATE SURVEY COMPLETED		
		155764	B. WING			08/22/2012	
NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS				10	EET ADDRESS, CITY, STATE, ZIP CODE D1 W 87TH AVE ERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE	